

AIDS Drug Assistance Programs (ADAPs)

April 2009

What are ADAPs?¹

AIDS Drug Assistance Programs (ADAPs) provide HIV-related prescription drugs to low-income people with HIV/AIDS who have limited or no prescription drug coverage. With more than 183,000 enrollees, ADAPs reach approximately one-third of people with HIV estimated to be receiving care nationally.² In June 2008 alone, ADAPs provided medications to about 110,000 clients and insurance coverage to thousands more.

ADAPs began serving clients in 1987, when Congress first appropriated funds to help states³ purchase the only approved antiretroviral (ARV) drug at that time, AZT. In 1990, they were incorporated into the newly enacted Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, now known as the Ryan White Program.^{4,5} Since Fiscal Year (FY) 1996, Congress has specifically earmarked funding for ADAPs through Part B of the Ryan White Program, which is allocated by formula to states.⁶ The most recent reauthorization of the Ryan White Program, in 2006, changed the way in which federal funding is distributed to states for ADAPs and led to new requirements, including a minimum formulary requirement.

In FY 2008, 58 jurisdictions received ADAP earmark funding, including all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, American Samoa, Federated States of Micronesia, Guam, Marshall Islands, and Northern Mariana Islands.⁷ ADAPs may also receive state funding and contributions from other sources, including other parts of the Ryan White Program, but this support is highly variable and largely dependent on local decisions and resources. ADAPs are not entitlement programs; annual federal appropriations and, where available, funding from other sources, determine how many clients ADAPs can serve and the level of services they can provide. Each state operates its own ADAP, including determining eligibility criteria and other program elements, resulting in significant variation across the country.

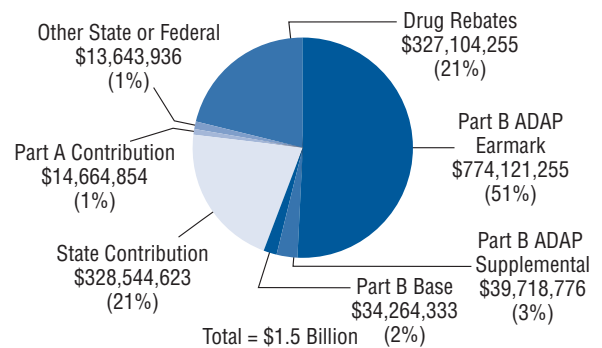
ADAP Budget

The ADAP budget has increased over time, although the levels of funding and budget composition are highly variable from year to year, and influenced by a broad range of factors.

- The national ADAP budget reached \$1.5 billion in FY 2008, an increase of 8%, or more than \$100 million, over FY 2007. Since FY 1996, the budget has increased nearly 8-fold.
- The federal ADAP earmark⁸ is the largest component of the budget (51%), although it has declined as a share of the budget in recent years.
- State funding and drug rebates each accounted for 21% of the budget. Drug rebates were the largest driver of budget growth over the last year.
- ADAP Supplemental Drug Treatment Grants accounted for 3% of the overall ADAP budget; other federal or state sources accounted for the remaining 4% of the budget.

- In addition to ADAP earmark funding, in FY 2008, 34 ADAPs received state funds; 41 received drug rebates; 16 received ADAP supplemental funds; 21 received Part B base funds; and 7 received Part A funds. Despite an increase in the national ADAP budget, 21 ADAPs experienced net decreases in their budgets.

Figure 1: The National ADAP Budget, by Source, FY 2008



ADAP Expenditures and Prescriptions

Nearly all ADAP expenditures are for prescription drugs and drug spending has increased over time, but at slower rates in recent years.

- ADAP spending on prescription drugs (directly or indirectly through insurance coverage) totaled \$1.2 billion in FY 2007, accounting for 97% of program expenditures.
- In June 2008, drug expenditures totaled \$109.5 million and ADAPs spent an additional \$9.7 million on insurance purchasing/maintenance.
 - Per capita drug spending was \$1,005.
 - ADAPs filled 361,366 prescriptions.
 - The average expenditure per prescription was \$303. ARVs accounted for the bulk of drug expenditures (91%), and expenditures per prescription were about 6 times higher for ARVs than non-ARVs.
- ADAP drug spending increased more than 7-fold (617%) since 1996, more than twice the rate of client growth over the same period; spending grew by 9% between June 2007 and June 2008.

ADAP Formularies

ADAP formularies (the list of drugs covered) vary significantly across the country.

- Formularies ranged from a low of 28 drugs offered in Idaho to 466 in New York, and open formularies⁹ in 3 jurisdictions (Massachusetts, New Hampshire, New Jersey).
- The majority of ADAPs (30) covered every approved ARV in each ARV class as well as the one approved multi-class combination product.

- 36 ADAPs covered 16 or more of the 31 “A1” drugs highly recommended (“A1”) for the prevention and treatment of opportunistic infections (OIs).¹⁰
- 29 ADAPs covered drugs for the treatment of hepatitis C; 30 covered hepatitis A and B vaccines.

ADAP Clients

ADAP client enrollment and utilization have grown over time and reached their highest levels to date. Client demographics vary by state and region, but nationally have remained fairly constant over time.

- 183,299 people were enrolled in ADAPs in FY 2007, including 36,354 clients who were newly enrolled.
- In June 2008, ADAPs provided medications to 110,047 clients across the country; thousands more were provided with insurance coverage.
 - Most clients were people of color (63%) and most were male (77%).
 - Most had incomes at or below 200% of the Federal Poverty Level or FPL (74% of clients), including more than 4 in 10 (42%) with incomes at or below 100% FPL.¹¹
 - A majority was uninsured (72%), with only small shares reporting some other source of coverage (17% private; 13% Medicare; 11% Medicaid; 2% with both Medicare and Medicaid).
 - Of clients whose CD4 counts were reported, half (51%) had counts of 350 or below (at time of enrollment or recertification).
- The number of clients served has grown more than 3-fold (254%) since 1996. Client utilization increased by 15% between June 2007 and June 2008, the largest increase reported since 1999.

ADAP Eligibility Criteria

The Ryan White Program requires all ADAP clients to be HIV positive, low-income, and under- or uninsured, but no income level is specified under current law. Each ADAP determines its own income eligibility as well as other eligibility criteria.

- All ADAPs require documentation of HIV status. Seven use additional clinical eligibility criteria (e.g., specific CD4 counts or viral load ranges).
- All ADAPs have state residency requirements, and many require proof of residency.
- Financial eligibility ranges from 200% of the FPL in 10 states to 500% FPL in 7 states.¹¹ Seventeen ADAPs also use asset limits to determine eligibility.

- Fewer ADAPs reported instituting cost-containment measures and maintaining them through the end of the fiscal year compared with last year’s report. One state, Montana, instituted additional cost-containment measures (not including a waiting list) in FY 2008. However, 7 other ADAPs are anticipating the need to implement measures during the upcoming fiscal year.
- Despite being eliminated in September 2007 for the first time in years, waiting lists reemerged in January 2008. As of March 2009, 3 ADAPs had waiting lists—Indiana, Montana, and Nebraska—with a total of 62 people.

Drug Purchasing Models and Insurance Coverage

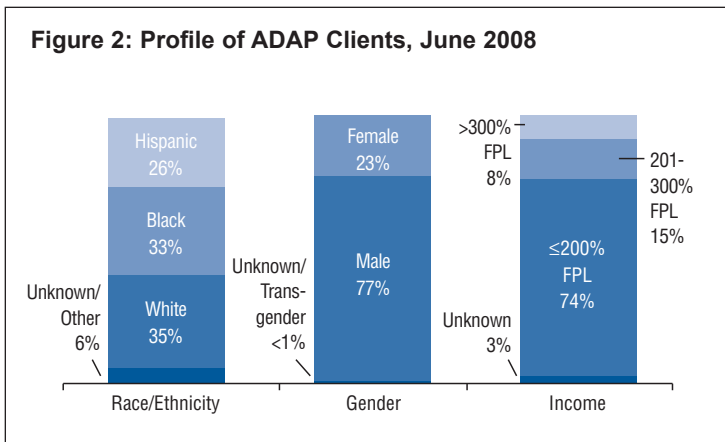
- All ADAPs participate in the 340B program, enabling them to purchase drugs at or below the statutorily defined 340B ceiling price.
- 29 ADAPs purchase drugs directly from wholesalers; 25 purchase drugs through a pharmacy network.
- 37 ADAPs used funds for purchasing health insurance and/or paying insurance premiums, co-payments, and/or deductibles for clients in 2008, paying for coverage for 15,843 clients in June 2008. ADAPs spent \$9.7 million in June 2008 and an estimated \$106.7 million in FY 2008 on insurance coverage.

Medicare Part D

Since the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which added a new outpatient prescription drug benefit, Part D, to the Medicare program, ADAPs have been working to coordinate with Medicare drug plans. As the payer of last resort, ADAPs are required to ensure that any Medicare Part D-eligible client is enrolled in Part D or ensure that ADAP is not paying for any of their Part D covered expenses. ADAPs reported the following: 33 ADAPs paid for Part D co-payments; 28 paid for deductibles; 25 paid for premiums; and 29 paid for medications on their ADAP formularies when clients reach the Part D coverage gap (or “doughnut hole”).

Looking Ahead

ADAPs continue to play a critical role in providing prescription drugs to low-income people living with HIV who have limited or no access elsewhere. In addition, ADAPs often serve as a bridge to other care and support services. As the number of people living with HIV has increased in the U.S., largely due to advances in HIV treatment, so too has the need for ADAPs. Looking ahead, there are several key developments that may affect ADAPs in the coming year. Changes from the most recent reauthorization of the Ryan White Program in 2006 are still playing out for ADAPs and Congress must take action by the end of September 2009 to continue the Ryan White Program; a new authorization could lead to further changes for ADAPs. The nation’s recession and the challenging state fiscal conditions are already being felt by ADAPs and the programs could face additional demand for services and strain on resources in the coming year.



Cost-Containment Measures and Waiting Lists

ADAPs must balance client demand with available resources on an ongoing basis. As a result, instituting cost-containment measures or waiting lists sometimes becomes necessary.

¹ All data in this fact sheet are from the *National ADAP Monitoring Project Annual Report*, April 2009.
² Based on KFF analysis of data from CDC.
³ The term “state” includes both states and territories.
⁴ Pub. L. 101-381; Pub. L. 104-146, SEC. 2616. [300ff-26].
⁵ HRSA, HIV/AIDS Bureau.
⁶ Five percent of the ADAP earmark is set-aside for the ADAP Supplemental Drug Treatment Grant.
⁷ Palau was eligible to receive funding in FY 2008 but did not report any HIV/AIDS cases and therefore did not receive a funding award.
⁸ Not including the ADAP Supplemental Drug Treatment Grant set-aside.
⁹ Providing any FDA-approved HIV-related prescription drug.
¹⁰ See <http://aidsinfo.nih.gov/Guidelines/Default.aspx?MenuItem=Guidelines> for current guidelines.
¹¹ The 2008 Federal Poverty Level (FPL) was \$10,400 annually (slightly higher in Alaska and Hawaii) for a household of one.